DOCUMENT RESUME

ED 269 683 CG 019 068

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TITLE Differentiating Conduct Disorder from Depressive Disorders in School Age Children.
PUB DATE Apr 86
NOTE 27p.; Paper presented at the Annual Meeting of the American Educational Research Association (70th, San Francisco, CA, April 16-20, 1986).
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Adolescents; *Aggression; *Behavior Disorders; *Children; *Depression (Psychology); Discipline; Family Influence; Identification; *Locus of Control; *Parent Child Relationship; Parent Influence; Problem Children

ABSTRACT

Due to similarities in symptomatology, childhood depression has often been misdiagnosed as conduct disorder. Differentiating between the two disorders would help to direct the appropriate interventions for each disorder. Children (N=48) between the ages of 6 and 13 years and their parents participated in a study designed to analyze variables which could discriminate children who display depressive or conduct disorders from those who are free of significant disturbance. Children were selected by their teachers or school counselors as being conduct disordered or normal in conduct. Sixteen of the subjects were normal controls screened for psychopathology. The remaining 32 conduct disordered subjects were administered the Children's Depression Inventory and were classified as either depressed (N=16) or as conduct disordered (N=16). Children also completed the Nowicki-Strickland Locus of Control Scale for Children and the aggression scale of the Frost Self-Description Questionnaire. Parents completed the Beck Depression Inventory, the Maryland Parent Attitude Survey, and the Family Adaptability and Cohesion Evaluation Scales II. A two-group discriminant function analysis identified five variables that maximally differentiated the depressed/acting out group from the conduct disordered group: parental disicpline, locus of control, parental depression, interalized aggression, and family adaptability. These variables support research suggesting that depressed children often have a depressed parent; receive harsh, power-assertive discipline from their parents; have a rigidly adaptive family style; have a more internal locus of control; and tend to internalize aggression more than do non- depressed conduct disordered children. (NB)

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DIFFERENTIATING CONDUCT DISORDER FROM DEPRESSIVE DISORDERS IN SCHOOL AGE CHILDREN

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CG 019068

Presentation at the
American Educational Research Association
1986 Annual Meeting, April
San Francisco, California

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DIFFERENTIATING CONDUCT DISORDER FROM DEPRESSIVE DISORDERS IN SCHOOL AGE CHILDREN

Introduction

Within the past 20 years the entity of childhood depression has found much recognition (Cytryn & McKnew, 1972); however, it has often been misdiagnosed as a "conduct disorder" due to parallels in the presenting symptomatology of the two clinical disorders (Carlson & Cantwell, 1980). Both disorders can in fact be present at the same time, making accurate diagnoses difficult (Puig-Antich, 1982). Few studies exploring the differences between depressed and conduct disordered children or the variables contributing to their relationship have ever been undertaken (Puig-Antich, 1982).

The aim of the present study was to analyze variables which could discriminate children between the ages of 6 and 13 who display depressive disorders or conduct disorders with children who are free of significant disturbance.

There would be benefits in being able to more positively differentiate children whose acting out contains a depressive element from those who have conduct disorders alone. Within the school system, conduct disordered children's acting out behavior is met with punishment. While this might be appropriate, the depressed child,

showing many of the same behaviors, may not respond to such procedures well and could, in fact, have a negative effect.

In counseling families of such children, two general intervention strategies are utilized. With acting out/conduct disordered children--because they are thought to be more externally oriented--their environment is structured to a greater degree and the emphasis is on limit setting and the like. However, if a depression is found to be behind the acting out behavior, externally oriented interventions are likely to be ineffective. An alternative, more internally oriented intervention strategy focusing on the child's negative esteem will be necessary.

Families of acting out children often punish and chastise their children during their periods of acting out. Should such a child also be depressed, such parental reactions would only exacerbate the child's problems. In summary, a true understanding of the differences between the two disorders would have the ultimate effect of directing the appropriate interventions for each.

Prior to the diagnostic emphasis on more observable behaviors in diagnosing psychological disorders, which characterizes the DSM-III (American Psychiatric Association [APA], 1980), the relationship between depressive disorders in childhood and conduct disorders in childhood were entertained as having commonalities between themselves. In many instances, conduct disorders were viewed as "masking" over an underlying depressive disorder due to acting out

behaviors common to both disorders (Cytryn, McKnew, & Bunney, 1980). Few studies have addressed similarities and differences between these two groups of disorders, or the variables that determine their relationship.

Variables Implicated In Differentiating Depressed from Nondepressed Conduct Disordered Children

Parental variables have largely focused on concordance between parent and child on severity of depression. Current research suggests that children parented by one who is depressed stand a significantly greater probability of developing an affective disorder as well (McKnew, Cytryn, Efron, Gershon, & Bunney, 1979; Welner, Welner, McCrary, & Leonard, 1977).

Maternal rejection, which can be experienced as object loss by children, has been closely associated to childhood depression (Crook, Raskin, & Eliot, 1981) but not to the extent as have conduct disorders. Conduct disordered children are theorized not to have developed an adequate affectional object bond. Rejecting parental attitudes would serve to reinforce the depressed child's symptomatology to a greater degree than the conduct disordered child's (Kashani, 1983). Such children do not feel protected, and experience intense pressure to please their parents so as to escape rejection and responsibility for what negative events might occur naturally (Malmquist, 1977).

Ferholt et al. (1985) have noted that depressed children's early childhoods were characterized by a pervasive and persistently tense and angry emotional exchange between mother and child. Such parents made disparaging remarks and held rejecting feelings towards their children, inducing a "negative mental portrait."

Parental style of disciplinary practices may also be a differentiating factor. It appears that parents of both depressed and conduct disordered children employ harsh power-assertive methods of discipline; however, parents of depressed children appear to exercise the additional use of shaming and inflicting of guilt (Blumberg, 1981; Frank, 1983; Perris, 1983; Peterson, Southworth, & Peters, 1983). The former style of disciplinary practices would account for the aggressive acting out observed in both disorders, whereas the addition of the latter means could potentiate the children's depression. Parents of conduct disordered children are generally seen as more lax and indulgent in their overall parenting practices as a result of their greater lack of attachment (Peretti, 1980). Lowenstein (1977) observed that parents of "bullying" children were often overpermissive with their children, leading to externally oriented, acting out behaviors. This orientation can in turn lead to undersocialization and delinquent acting out.

The nature and degree of the child's aggressive acting out may help discriminate depressed from nondepressed groups

(Lesse, 1974). Aggression can be either externalized or internalized. Conduct disordered children are generally considered to externalize aggression while psychodynamic and cognitive models theorize aggression as being more internalized in depressed individuals (Beck, 1972a). However, depressed children often act out as well (Carlson & Cantwell, 1980).

The classification structure of Edelbrock and Achenbach (1980) places depressed children in the internalizing category even though aggressiveness is included. Delinquent/conduct disorders were categorized within the externalizing class. As this dichotomy is roughly comparable to a model of internal and external locus of control (Gordon, 1983), such variables should serve towards differentiating the two groups.

On a dimension of family cohesiveness, children in disengaged family systems feel a sense of deprivation due to a lack of parental interest which may be attributed to something they have or have not done (O'Brien, 1983), resulting in guilt feelings and low self-esteem. The extent to which conduct disordered children are disconnected from the family appears to be less than that of depressives, although in the same direction due to a similarity in backgrounds (Winter & Ferreira, 1971).

Adaptability focuses on the family system's ability to change. As such, families with a more rigid style should contribute more to a child's depression than a more flexible

one. "Close minded" or rigid families have little capacity for recognizing affects, dealing with affects, or talking about affects in a meaningful way (Anthony, 1977).

Methodology

Subjects

Three groups of 16 children whose ages ranged from 6 to 13 years and their mothers served as subjects.

Experimental group subjects were selected from among the conduct disordered children initially referred for possible inclusion in the study. Teachers and school counselors (see Procedures section) responded to previously disseminated behavioral descriptions detailing the diagnostically significant characteristics of acting out/conduct disordered children; students they judged to be of normal character; and those whose conduct was seen as being outstanding. In proportion to the number of acting out children included as experimental subjects, the children identified as being of average or above average in character were utilized as control group subjects. All subjects were referred from California school districts within Fresno County including special education programs. Referrals from the area's private schools for emotionally disturbed children were included as well.

All children must have been living within the household for a minimum of six months. Children suspected of mental retardation were not included.

Conduct disorder groups (depressed and not depressed). Children included in the conduct disordered group ranged in age from 6 to 13 years, with a mean age of 9.9 years.

Of the 32 conduct disordered children, those who received a raw score of 11 points or greater on the Children's Depression Inventory (see Instruments) were then designated as the depressed/conduct disordered group. Although such children had conduct disorders and were acting out, they were also seen as significantly depressed. Children not scoring within the depressive range on the Children's Depression Inventory remained in the conduct disordered group.

Normal control group. Children comprising the normal control group ranged in age from 6 to 13 years, with a mean age of 9.5 years. Other than to be roughly approximate to the ages of subjects in the other groups, children comprising the normal group were selected initially by teachers who estimated them to be of average or above average conduct--originating from the same classes from which the acting out children were identified--making them representative of the experimental groups. All normal controls were screened to ensure they were free of any serious psychological disorder. Table 1 summarizes the groups in terms of demographic information.

Instruments

Depression. To assess children's level of depression and determine experimental group assignment, the Children's

Table 1

Demographic Data by Group Membership

	Depressed/Conduct Disorder	Conduct Disorder	Control
Sample Size	16	16	16
Mean Age	10 (2.16)	9.9 (1.88)	9.5 (2.42)
Sex:			
Male	13	10	10
Female	3	6	6
Race:			
Caucasian	12	11	12
Hispanic	2	4	3
Black	2	1	1
Income:			
Low	8	8	5
Middle	7	7	9
High	1	1	2
Children's Mean Depression Score	17 (3.24)	6.6 (2.13)	4.9 (5.5)

Values in parentheses are standard deviations.

Income categories: lower = $5,000-$15,000; middle = $16,000-$40,000; high = $40,000 and above

Depression Inventory (CDI), constructed by Kovacs (1982), was utilized. The scale is suitable for children up to age 17 years (Kovacs, 1983). The CDI is a 27-item scale in which each item consists of three choices. The item choices are keyed from 0 to 2 in the direction of increasing depressive symptomatology, yielding a possible score from 0 to 54. The child is to select the one sentence for each item that best describes him or her during the past two weeks. The items are read aloud while the child follows on the test paper marking the answers. The scale requires approximately 15 minutes to administer. Kovacs (1983) notes a total score of 11 points on the CDI is adequate to identify the majority of depressed cases.

The Beck Depression Inventory was chosen to measure the corresponding level of depression in the mothers of children in the study. The Beck Depression Inventory (BDI) (Beck, 1972b) is a self-admininstered scale designed to assess adult levels of depression. The BDI consists of 21 items. Scores range from 0 to 63. Scores of 0 to 9 fall within the normal range, 10 to 15 indicate mild depression, 16 to 23 moderate depression, and 24 to 63 severe depression.

Parental attitudes. The Maryland Parent Attitude Survey (MPAS) (Pumroy, 1966), a research instrument designed to measure parent attitudes toward childrearing with social desirability controlled, was selected to test the hypothesis that parents of depressed children would score as more rejecting, disciplinarian, and as less indulgent and

protective than parents of children with conduct disorders alone. The 95-item test requires about 30 minutes to complete. The MPAS yields four subscales useful to the current study: indulgent, disciplinarian, protective, and rejecting.

Locus of control. The Nowicki-Strickland Locus of Control Scale for Children (NSLCSC) developed by Nowicki and Strickland (1973) was chosen to assess the direction and degree of orientation. The NSLCSC consists of 40 items to which "yes" or "no" answers are given. The scale is designed for children between grades 3 through 12, but may be used with younger children. The scale was constructed on the basis of Rotter's definitions of external and internal control. Sample items from the NSLCSC are: "Are some kids just born lucky?" and "Do you believe that most problems will solve themselves if you just don't fool with them?" Higher scores are associated with greater externality. The scale requires about 15 minutes to administer. The scale was normed on 1,017 elementary and high school students. Split-half internal consistency coefficients range from .63 to .81. Test-retest reliability coefficients over a six-week period ranged from .66 to .71.

Aggression. To measure the amount and style of aggression displayed by the children in the study, the externalized aggression and internalized aggression scales of the Frost Self-Description Questionnaire (FSDQ) were adopted. Developed by Frost (1973), the entire test

contains 14 scales (plus buffer items) designed as a screening device to assess level of anxiety, externalized aggression, projective and internalized aggression, the degree to which denial is used, and whether the child is affiliative or submissive to denial. Seventeen items compose the two scales, requiring about 10 minutes to administer.

Family assessment. The revised edition of the Family Adaptability and Cohesion Evaluation Scales (FACES II) (Olsen, Portner, & Bell, 1982) was used to measure the degree of family connectedness and flexibility. The FACES II is a 30-item scale wherein each item is rated on a 5-point response scale requiring about 15 minutes to complete.

The family cohesion scale assesses the degree to which family members view themselves as separated from or connected to their family. Olsen, Russell, and Sprenkle (1983) define family cohesion as "the emotional bonding that family members have toward one another" (p. 5). Concepts included in the family cohesion scale include: emotional bonding, boundaries, coalitions, time space, friends, decision-making, interests, and recreation.

The family adaptability scale measures the extent to which the family is flexible and able to change. Olsen et al. (1983) have defined family adaptability as "the ability of a marital or family system to change its power structure, role relationships, and relationship rules in response to situational and developmental stress" (p,. 5). Concepts

included in this dimension are: family power, negotiation style, role relationships, and relationship rules.

The family cohesion and family adaptability dimensions are plotted on a circumplex model. There are four levels of family cohesion ranging from extreme low cohesion (disengaged) to extreme high cohesion (enmeshed). Similarly, the family adaptability scale has four levels, ranging from extreme low adaptability (rigid) to extreme high adaptability (chaotic). Within each dimension, moderate scores are seen as indicating healthy family functioning.

Olsen et al. (1983) report a split-half reliability coefficient of .90 and a test-retest Pearson correlation of .84 based on a sample of 2,412 families. Construct validity is estimated utilizing factor analysis. The FACES II was normed on a national sample of 2,082 parents and 416 adolescents.

Procedures

Each identified child's family was sent a cover letter explaining the purpose of the study and, in a diplomatic fashion, why they in particular were identified. The children's parents were informed that the purpose of the study was information gathering in nature and would in no way call attention to or exploit their child's difficulties.

Before each family's interview began, they were told that many families had been chosen to ensure a wide range of family styles would be studied and that they were in no way

being singled out. The parents were further informed that children differ widely in how they feel about themselves and act around others. This same approach was incorporated in explaining that parents differ on their views of how children should be reared and how each family's style of interacting was unique.

Before the study's instruments could be administered, the criteria for conduct disorder as laid out in the DSM-III (APA, 1980) must have been met. The "normal control" candidates were screened for signs of any serious psychopathology. The decision for inclusion into the different groups was made by the experimenter, utilizing the DSM-III criteria and parental report of symptomatology. If during the interview the criteria for conduct disorder could not be met, the interview was continued so as not to call attention to any perceived shortcomings on the part of the family. These data were not included in the analysis, however.

During the interview, the identified child was assessed, first being administered the Children's Depression Inventory. According to the children's scores on the Children's Depression Inventory, they were later assigned to either the depressed group or the conduct disorder group. The children were then administered the NSLCSC and the aggression scales of the FSDQ. The children's parent was then interviewed apart from their child. The parent completed the Beck Depression Inventory, the Maryland Parent Attitude Survey, and the FACES-II.

Following the interview, the parents were debriefed about the study and any questions they might have had were addressed.

Results

The data generated from the above procedures were analyzed by stepwise discriminant function analysis. The dependent variable was group membership (depressed conduct disordered, conduct disordered, normal control). The independent variables were parental depression, parental indulgence, parental discipline, parental protectiveness, and parental rejectingness; children's locus of control, internalized aggression, and externalized aggression; family adaptability and cohesion. As can be seen in Table 2, all of the variables were univariately significant at the .01 level. The stepwise discriminant function analysis accounted for 88% of the difference between the three groups.

Due to the control group's scores being significantly different from the two study groups on nearly every predictor variable, a second analysis including only the depressed/conduct disorder and conduct disorder groups was carried out.

This second stepwise discriminant function analysis resulted in a significant function. The Wilks's Lambda was .24, which was significant ($p < .01$) with a chi square value of 39.20. This function accounted for 76% of the variability. Table 3 presents the standardized discriminant

Table 2

Predictor Variable Summary Statistics Broken Down by Group

Variables	Group Means and Standard Deviations Depressed	Conduct Disordered	Control	Eta^2
Parental depression	13.38 (7.08)	6.19 (4.69)	5.19 (3.06)	.34*
Parental indulgence	16.06 (4.97)	21.81 (3.27)	22.44 (5.03)	.30*
Parental discipline	29.31 (5.44)	23.19 (4.29)	23.00 (4.13)	.30*
Parental protectiveness	21.19 (3.45)	24.94 (4.45)	28.44 (3.01)	.41*
Parental rejectingness	27.56 (5.06)	20.62 (3.20)	14.75 (5.18)	.58*
Locus of control	23.38 (3.24)	18.06 (3.77)	25.00 (3.12)	.45*
Internalized aggression	4.50 (1.79)	2.19 (1.28)	1.50 (.73)	.50*
Externalized aggression	4.62 (2.42)	4.62 (1.26)	.75 (.68)	.57*
Family cohesion	48.38 (9.33)	59.06 (4.84)	65.50 (4.40)	.55*
Family adaptability	44.31 (7.55)	45.06 (6.41)	54.75 (7.94)	.31*
Children's depression	17.06 (3.24)	6.56 (2.13)	4.88 (5.51)	.67*

*$p < .01$ univariate F-test

Standard deviations in parentheses

Table 3

Standardized Discriminant Function Weights and Structure Coefficients for Two-Group Analysis

Variables	Weights	Structure Coefficients
Locus of control	.88	.44
Family adaptability	-.69	-.03
Internalized aggression	.59	.43
Parental depression	.49	.35
Parental discipline	.47	.36

function weights for the function. Presented next to the weights are the structure coefficients for each variable included in the function. The only variables shown are those comprising the function. The major contributing variables in this function were Locus of control, Family adaptability, Internalized aggression, Parental depression, and Parental discipline. Thus, a subject (parent/child) scoring higher on Locus of control (more internal), lower on Family adaptability, higher on Internalized aggression, Parental depression, and Parental discipline was identified as being in the depressed/conduct disorder group.

As noted in Table 2, nearly every predictor variable was univariately significant at the .01 level. Newman-Kuells post hoc test results indicated that the depressed/conduct disorder group was significantly different from the conduct disorder group on the measures of Parental depression, Parental indulgence, Parental discipline, Parental protectiveness, Parental rejectingness, Locus of control, Internalized aggression, and Family cohesion.

As can be seen in Table 4, most of the predictor variables were significantly intercorrelated when the three groups are pooled. All of the parenting attitude predictor variables intercorrelated significantly. Family cohesion also correlated significantly with every other predictor variable except children's Locus of control, which helps to explain why this variable, while univariately significant, was never selected by the stepwise procedure in the

Table 4

Pearson Correlation Coefficients for the Predictor Variables Based on the Total Sample Population

	Par Dep	Indulg	Discip	Protect	Reject	Locus	I. Agg	E. Agg	Cohes	Adapt
Parent Depression										
Indulgent	-.49*									
Discipline	.50*	-.61*								
Protective	-.44*	.40*	-.45*							
Rejecting	.53*	-.64*	.44*	-.65*						
Locus	-.08	-.12	.00	.06	-.07					
Internal Aggression	.48*	-.51*	.45*	-.36*	.45*	.07				
External Aggression	.34*	-.24*	.37*	-.49*	.41*	-.39*	.53*			
Cohesion	-.54*	.40*	-.37*	.55*	-.66*	-.06	-.54*	-.49*		
Adaptability	-.22	.22	-.06	.41*	-.50*	.23	-.10	-.26*	.49*	

*p < .05

discriminant function analyses. Children's Locus of control stood out as the only predictor variable that did not correlate significantly with any other variable.

Several of the parenting attitude variables were also significantly related to one another within each group.

Within the depressed/acting out group, Parental discipline correlated positively with Parental rejection ($r = .65$, $p < .01$) and negatively with Parental indulgence ($r = -.60$, $p < .01$). A moderate but nonsignificant correlation of -.38 resulted in the relationship between Parental protectiveness and Family discipline. As expected, Parental rejection was significantly negatively correlated with Parental protectiveness ($r = -.51$, $p < .05$) and Parental indulgence ($r = -.77$, $p < .01$). Protection correlated significantly with Indulgence ($r = .45$, $p < .05$).

Within the conduct disordered group, none of the four parenting variables correlated significantly with one another.

Within the control group, Discipline was significantly negatively correlated with Indulgence ($r = -.60$, $p < .01$). As expected, Rejection was significantly negatively correlated with Protection ($r = -.48$, $p < .05$). Of interest is the moderate but nonsignificant correlation between Discipline and Rejection ($r = -.35$, $p = .09$), illustrating that the two concepts/practices are not necessarily related. This is in contrast to the significant positive correlation

between these two variables found in parents of the depressed children ($r = .65$, $p < .01$).

There are several significant relationships between the Internalized aggression, Externalized aggression, and Locus of control variables within each group. Within the depressed group, Internalized aggression was significantly correlated with Externalized aggression ($r = .45$, $p < .05$), with scores for both variables in the elevated range. There was no such relationship in the conduct disordered group ($r = .09$).

Discussion

The use of the control group compromises the predictor variables' ability to differentiate the two study groups since it was demonstrated to be significantly less pathological on every variable. The two-group discriminant function addressed this issue by comparing only the two study groups. As a result, subjects who scored higher on Parental depression, Parental discipline, Locus of control, and Internalized aggression, and lower on Family adaptability, would be identified as being in the depressed/conduct disorder group.

This predictor variable list supports research suggesting that depressed children often have at least one parent who is depressed as well (Poznanski & Zrull, 1970); and that their methods of discipline employ harsh, power-assertive techniques (Frank, 1983). That these children have a more internal locus of control and tend to

internalize aggression more than non-depressed conduct disordered children lends support to findings by Beck (1972a), Edelbrock and Achenbach (1980), and Gordon (1983). The more rigidly adaptive family style of the depressed child finds support from Anthony (1977) and Rutter and Madge (1977).

In sum, the two-group discriminant function analysis identified five variables that maximally differentiated the depressed/acting out group from the conduct disordered group. Such a variable list differentiated the two groups and identified the depressed children who are normally difficult to discern from conduct disordered children who are not significantly depressed. Use of the five identified brief assessments from the two-group discriminant analysis could lower the "60% miss rate" for identifying depressed children from among those with a conduct disorder as reported by Carlson and Cantwell (1980).

It appears that dealing with depressed children's acting out has misdirected intervention strategies. These children's provocative behaviors have historically elicited punishment or rejection, which has, if anything, had the effect of reinforcing the depression. It may be concluded from this study that conduct disordered children who come to professionals' attention need to be screened for depressive symptomatology. If a depressive disorder is found, it must be given priority over the acting out behavior in terms of therapeutic interventions. Evidence of this was shown in a

sample of depressed children studied by Puig-Antich (1982). Upon completion of trials using antidepressant medication, depressed children with concomitant conduct disorders showed a marked decrease in negative behaviors, thus supporting this priority.

As measures and criteria such as those included in the present study become further refined, differentiating the two groups can be enhanced thus leading to more effective treatment strategies.

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